Action Plan Guide

1. The Individual Service Plan is being expanded and is called the Person Centered Support Plan (PCSP).

The plan includes identifying information, a summary of the assessment information, the Action Plan, the budget, and other required information currently in the ISP. The Action Plan will be similar in format to what we have now but will be expanded to include more information about all supports and services. The Action Plan has three Parts:

A. List supports and services by personal goal (one or more),
B. List additional supports and services (not goal related)
C. List of Purchased Services, which includes the amount, duration, and frequency for each service. Waiver-services also include brief service descriptions.

2. The Action Plan is the implementation of the planning process.

The process outlines the person's personal goals, the primary supports and services, and makes clear assignments for who is going to do what.

3. Action Plans provide the critical link between assessments, supports and services.

Members of the person's circle of support/team commit to specific supports and services designed to maximize the possibility that the person's goal will be achieved. Note: the term "personal goals" is used instead of "desired outcomes"; however, they refer to the same thing. The term "personal goal" is more useful to avoid confusion with past Quality Enhancement Team's or The Council's use of the "twenty-five outcomes," which are not the same as a person's individualized desired outcome or personal goal.

4. The Action Plan is developed by the person's circle of support at the conclusion of the person-centered planning meeting.

The Division Support Coordinator documents the Action Plan along with the other elements of the PCSP. These planning documents, including the Action Plan, needs to be reviewed and updated at least every twelve months at a Planning meeting; however, people's lives do not revolve around the calendar so anticipate more frequent changes. The Action Plan should be updated only when a change in services or assignments are needed.

5. The Action Plans format was designed to encourage and enable the application of basic person-centered principles.

No specific form/template can ensure these person-centered principles are adhered to. So it is up to each individual circle of support to know these principles and diligently monitor their own performance. This still meets the Division's requirements and the waivers' requirements. The Action Plan outlines the basic services provided including all waiver services, who will provide them (provider's contract outlines minimum contract expectations),

tells the provider what their supports should focus on, and outlines specific support strategies they are expected to develop, implement and evaluate.

6. The Action Plan is organized around the person's goals.

It is imperative to start the process with what the person wants, what is most important to them, and by addressing their core values and passions. It is not person-centered planning if the plan is developed starting with the needs/disabilities of a client/consumer or supports/services that are currently in place. Teams may choose to also use a Short-term Goal to more clearly communicate the focus on a realistic goal for this year without loosing sight of the ultimate personal goal that has been identified.

7. Commitments or assignments are made at the level of the specific support or service and not at the broader personal goal level.

This is essential to encourage multiple people and agencies to address a single personal goal from different perspectives at the same time, maximizing effectiveness. Although in some cases a single assignment or support strategy may adequately address a goal, just dividing up the goals among providers will not result in a well coordinated, integrated, and effective Action Plan.

8. Natural supports and Medicaid State Plan Services should be considered first and included in the Action Plan.

Avoid small token assignments as after thoughts following commitments from Waiver service providers. Include other supports and services not funded through the Division. The Action Plan addresses the person's life, not simply a list of Division paid support and services. Some supports may be one-time or time limited and should be included. These are often things that can make an immediate positive impact on the person's life.

9. It is important to <u>not</u> view supports and services as prerequisites for the person getting what they want.

This would be following the old "get ready" model. Supports and services should be designed to maximize the chance the life the person desires will become reality and to begin to provide elements of that desired life immediately. There are situations when accommodation based services are the answer and other times when learning a new skill, creating an opportunity, or build relationships will be the focus. There are usually many ways to address an issue. Only the circle of support can decide which combination is best for any given situation. Remember the consumer's central role in selecting supports and services, not just in identifying personal goals.

10. The Action Plan provides clear expectations.

The Division funded supports are clearly explained by indicating when formal/written support strategies and monthly summaries adhering to the Division's standards are needed. This is critical for contract compliance and accountability and will end confusions about assignments. Any specific

expectations for providers should be included in the Action Plan if not addressed in the contract.

11. Health and safety, and habilitation issues must be addresses.

These are critical areas of need for most people in services and must be addressed in the PCSP. Health and safety needs should not be listed collectively or separately as a personal goal unless it is important to the person (what the person wants, what is most important in their life, addressing their core values and passions). Health and safety issues will not rise to the level of a personal goal based on the person agreeing they want to be healthy and safe or based on the fact that the major focuses of supports/services are addressing health and safety. The PCSP distinguishes between what is important to the person and what is important for the person. Most health and safety issues that require highlighting will be listed as personal goal related supports. If it is not a personal goal related support, it may be listed as "Non-Goal Related Supports and Services" (it is still important for the person and must be addressed). We are aiming for a balance between what is important to the person and what is important for the person - we need to address both!

12. Additional Supports and Services are designed to address critical issues.

The circle of support identifies critical issues that are not already addressed as "personal goal related" supports. Although the Action Plan is personal goal focused, there is a way to separately list Non-Goal Related Supports and Services in the Action Plan. They may not be listed as "personal goal related" because they are not related or the person does not want them listed as such. Remember if a paid service or formal/written support strategy is being assigned, it must be listed somewhere in the Action Plan.

13. Not all supports and services a contracted agency is expected to provide will be outlined in the Action Plan.

Critical information may be included in other sections of the PCSP, which agencies are expected to use in implementing supports and services and/or used in the development of specific support strategies. It is also important to remember agencies are responsible to comply fully with all Division contractual agreements even if not highlighted in the PCSP.

14. The last part of the Action Plan lists all the DSPD paid services.

This includes all waiver services and their required information. This list matches the lists in Part I and Part II when a DSPD paid service is given an assignment. This section will include all Waiver required information and link directly to the individual budget. The intention of listing this information separately is to include all the Waiver requirements without cluttering the previous parts of the Action Plan.

15. **The Division is requiring the use of a standard planning format/template.** This will insure that all Action Plans contain the standard elements. This is important to enable everyone involved to know what to expect and know where to look for certain information. This is also a requirement in order to build an electronic Support Coordinator system. The experience so far has been that more creative formats of Action Plans have left out critical elements and often do not meet the Division's standards or the person's need for a clear balanced plan.

16. **The following information is a guide to using the planning process.** It is up to each circle of support to come up with the right solution for the person in their unique situation. Deciding when to include a personal goal in the Action Plan and how many personal goals to address can be difficult. Make sure the personal goal is what the person wants the end result to be – not the supports to help them get there (not the means to an end but the "end"). Especially check for this problem if many small goals are listed with one support under each goal; often these can be reframed as supports and services and grouped together under one personal goal. Prioritize, what is most important to the person, what will make the biggest difference in their life; consider hopes, dreams, passions, and ambitions, as well as likes and preferences. There is not a set number of goals for anyone; some people will only focus on one personal goal, others will have many. Remember some people are big dreamers/planners while others are more concrete short-term planners; it needs to be individualized! Individualization is based on the person receiving services, not the Support Coordinator's or the provider's preferences and needs. Every personal goal identified in the assessment process does not need to be addressed in the Action Plan. Prioritize what to focus on now and list other personal goals as future goals.

17. **Using Formal Support Strategies,** There are no rules or contract statements addressing when to require a formal/written support strategy and how many formal support strategies should be assigned a provider. However, it seems Division funded supports should have at least one formal support strategy, with the exception such as transportation and respite services. In general, there will be some correlation between the person's budget and the number of formal support strategies. However, strategies vary so much it is hard to put any specific number in this guideline. Consider requiring a formal/written strategy when the following situations are present:
    A. When it is critical to overcome a barrier to the personal goal.
    B. When it is related to several different personal goals.
    C. When you need specific detailed guidelines for the people providing the support.
    D. When informal supports have not been effective.
    E. When it is the major focus for paid supports.
    F When coordination among several people or agencies is required.

G. When it is related to rights restrictions or restrictive/expensive services.

18. Using Informal Supports.

Informal supports might be considered when the following situations are present:

A. When the commitment to follow up is from natural supports (non-Division funded) member of the circle/team or Medicaid state plan services.
B. When it is an adjunct to someone else's assignment as a formal strategy.
C. When it is related and will help, but not critical or necessary.
D. When it is a lower priority than other formal strategies.
E. When the nature of the support or service does not fit with the Division's requirements for formal support strategies.
F. When it is a one-time or short-term event or action.

19. Documenting Formal Support Strategies.

Documenting a formal strategy in the Action Plan with a "Yes" requires the provider to develop the support strategy in writing. Indicating "No" leaves it up to the provider or person assigned if they want to have a written plan.

20. Things to Consider about Additional Supports and Services.

When deciding to add any Additional Supports and Services, consider the following:

A. Is it a critical health or safety need that requires special attention but was not address as a personal goal related support/service?
B. Include it if a formal support strategy is going to be assigned (see above for guidelines).
C. If it is outlined somewhere else in the Individual Service Plan and an agency is already addressing it, it may not have to be specifically detailed in the Action Plan. Examples of what would not need to be listed the Action Plan would include routine medical care/monitoring or supervision provided by a residential program.